

# Exhibit 47

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
NORTHERN DIVISION**

CHERYL GREENE, PERSONAL  
REPRESENTATIVE OF THE ESTATE  
OF DWAYNE GREENE, DECEASED,

Plaintiff,

Case No. 2:18-cv-11008-MAG-DRG  
HON. THOMAS LUDINGTON

v.

CRAWFORD COUNTY, SHERIFF KIRK  
WAKEFIELD, RANDELL BAERLOCHER,  
RENEE CHRISTMAN, KATIE TESSNER,  
DONALD STEFFES, WILLIAM SBONEK,  
TIMOTHY STEPHAN, JOEL AVALOS,  
DALE SUITER, AMY JOHNSON, DAVID  
NIELSON, LARRY FOSTER, SHON  
CHMIELEWSKI, NORTHERN LAKES  
COMMUNITY MENTAL HEALTH  
AUTHORITY, Nanci KARCZEWSKI  
AND STACEY KAMINSKI, LPC,  
Individually and Officially and Jointly and  
Severally,

Defendants.

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**DECLARATION OF C. DENNIS SIMPSON**

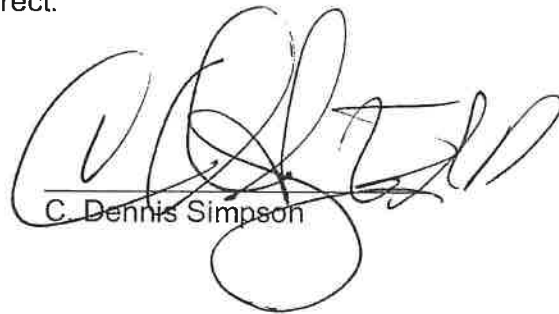
My name is C. Dennis Simpson. I am over eighteen years of age. I have personal knowledge of the facts stated herein and am competent to testify as follows:

1. Pursuant to 28 USC §1746, I declare the following.
2. I was retained by attorney Kevin Riddle to provide expert consulting services in the above captioned matter.

3. I have provided an expert report dated March 26, 2019, which is attached hereto and incorporated by reference to this Declaration.

4. I affirm the statements in the attached report and if called to testify at deposition or trial, I would testify to the statements, facts and opinions contained within my expert report.

5. I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.



C. Dennis Simpson

Executed this 19th day of December, 2019

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Greene v. Crawford County

Summary Opinion

March 26, 2019

C. Dennis Simpson, Ed.D.

Christopher A. Briggs, MA, LLP, CAADC

C.D. Simpson & Associates, Inc.

## Greene v. Crawford County: Summary Opinion

**Alcohol**

A central nervous system (CNS) depressant is a chemical compound that when consumed retards bodily processes. Depending on dosage, use of a depressant can result in decreased respiration rate, decreased heart rate, sedation, loss of consciousness and possible death (Wigmore, 2014; Korsmeyer and Krenzler, 2009). Alcohol, also known as ethanol or ethyl alcohol, is one such depressant.

Moderate doses of alcohol have been shown to affect memory, concentration, and insight while reducing anxiety and inducing relaxation (Boissoneault, Frazier, Lewis, & Nixon, 2016; Fillmore, 2007). As the dose increases, neuromuscular coordination is diminished followed by slowed reaction times and the development of faulty judgements (Fillmore, 2007; Amlung, Morris, & McCarthy, 2014; Brumback, Cao, & King, 2007; Dry, Burns, Nettlebeck, Farquharson, & White, 2012; Euser Van Meel, Snelleman, & Franken, 2011; Fogherty and Vogel-Sprott; Grant, Millar, & Kenny, 2000). Additionally, visual and auditory impairments have been observed under the influence of moderate to high dosages (Pearson, 1999; Upile, Sipaul, Jerjes, Singh, & Nouraei, 2007). At the highest dosages sleep, unconsciousness, and death can occur (Wigmore, 2014; Korsmeyer and Krenzler, 2009). In addition to the acute effects, chronic use can lead to sleep disturbances, seizures, organ damage, and psychoses as well as to numerous adverse cognitive conditions such as permanent memory loss, impaired attention, and increased occurrence of anxiety and depression (Walter and Bayen, 2016; George, Rogers, & Duka, 2005; Wigmore, 2014; Cromer, Cromer, Maruff, & Snyder, 2010; Weissenborn and Duka, 2003; Houston, Derrick, Leonard, Testa, Quigley, & Kubiak, 2014; Bennett, Cherek, and Spiga, 1993).

**Alcohol Withdrawal (AW)**

For a person who heavily uses alcohol, sudden decreases in alcohol intake can produce alcohol withdrawal (AW) symptoms, most of which are the opposite of those produced by intoxication (Jameson et al., 2018). The symptoms of AW reflect over-activity of the autonomic nervous system, a division of the nervous system that helps manage the body's response to stress. The diagnosis of AW as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is presented in Table 1.

The signs and symptoms of AW typically appear between 5 and 48 hours after heavy alcohol consumption ceases, peak on day 2 or 3, and improve by day 4 or 5, although mild levels of these problems may persist for 4 to 6 months as a protracted abstinence syndrome (Jameson et al., 2018; Myrick & Anton, 1998). Initial withdrawal symptoms may include headache, tremor, sweating, agitation, anxiety, irritability, nausea, vomiting, heightened sensitivity to light and sound, disorientation, difficulty concentrating. In the most serious instances of alcohol withdrawal, delusions, hallucinations, seizures, and death may occur. The initial symptoms typically intensify and then diminish over 24 to 48 hours (Myrick & Anton, 1998).

**Table 1. Alcohol Withdrawal Diagnostic Criteria**

Diagnostic criteria of alcohol withdrawal

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 Diagnostic and statistical manual of mental disorders (DSM-5) criteria for alcohol withdrawal
 

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- A. Cessation or reduction in alcohol use that has been heavy and prolonged.
  - B. Two (or more) of the following, developing within several hours to a few days after criterion A.
    - Autonomic hyperactivity, increased hand tremor, insomnia, nausea or vomiting, transient visual/auditory/tactile hallucinations or illusions, psychomotor agitation, anxiety, generalized tonic-clonic seizures
- 

About 5% of individuals with alcohol use disorders experience a withdrawal seizure, with the risk increasing in the context of older age, concomitant medical problems, misuse of additional drugs, repeated episodes of alcoholic detoxification, and consumption of higher alcohol quantities (Mainerova et al., 2015; Schmidt et al., 2016; Erwin, Williams, & Speir, 1998). The same risk factors also contribute to withdrawal delirium, also known as delirium tremens (DT), where the symptoms of delirium (mental confusion, agitation, and fluctuating levels of consciousness), auditory and visual hallucination, and tremor and autonomic over-activity (e.g., marked increases in pulse, blood pressure, and respirations) are more prominent (Mainerova et al., 2015; Schmidt et al., 2016; Palmstierna, 2001). Table 4 presents a timeline of symptomology associated with the development of AW.

### **Delirium Tremens (DT)**

Delirium tremens (DT), the most intense and serious syndrome associated with AW, is characterized by severe agitation; tremor; disorientation; persistent hallucinations; and large increases in heart rate, breathing rate, pulse, and blood pressure. The typical DT patient shows agitation, hallucinations and disorientation (Mirijello et al., 2015). DT occurs in approximately 5 percent of patients undergoing withdrawal and usually appears 2 to 4 days after the patient's last use of alcohol (Jameson et al., 2018; DeBellis, Smith, Choi, & Malloy, 2005; Myrick & Anton, 1998). Seizures occur in up to 25 percent of withdrawal episodes, usually beginning within the first 24 hours after cessation of alcohol use (Jameson et al., 2018). The reported numbers of patients who undergo a complicated course of alcohol withdrawal vary widely between 5 and 20% and are dependent on several factors such as the clinical setting of withdrawal, the applied therapeutic approach and individual characteristics of patients (Eyer et al., 2011; Saitz and O'Malley, 1997; Mennezier et al., 2008). It is generally accepted that DT occurs in the range of 4–16% (Mainerova et al., 2015; Schmidt et al., 2016; Eyer et al., 2011; Saitz and O'Malley, 1997; Mennezier et al., 2008). Risk factors associated with the development of DT are presented in Table 2.

**Table 2.**

## Development of DT

Factors associated with DT development	
	- History of previous DT
	- Recent withdrawal seizures, specifically if left untreated
	- Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA--Ar) $\geq 15$
	- History of sustained drinking
	- Patients with SBP $> 150$ mm Hg, or patients with HR $> 100$ beats/min
	- Last alcohol intake $> 2$ days
	- Age $> 30$ years
	- Recent misuse of other depressants such as benzodiazepines
	- Concurrent medical illness such as pneumonia or active ischemia

Treatment of patients with DT can be challenging and represent a medical emergency with an estimated mortality as high as 5% (Mainerova et al., 2015; Schmidt et al., 2016; Eyer et al., 2011; DeBellis, Smith, Choi, & Malloy, 2005; Schuckit et al., 2014). However, while the mortality of hospitalized patients with DT is currently estimated to be 5%; *if no medical intervention is sought (e.g. stabilization, benzodiazepine use, intensive care), mortality is as high as 35%* (Mainerova et al., 2015; Schmidt et al., 2016; Mayo-Smith, 2004). The recommended treatment for DT is intensive care by well-trained providers who closely monitor vital signs (Jameson et al., 2018; Mainerova et al., 2015; Schmidt et al., 2016). Table 3 presents the disposition based on assessment of Alcohol Withdrawal Syndrome (AWS).

**Table 3.**

## Disposition for AWS

Discharge with detoxification referral	- CIWA-Ar Score $\leq 8$
	- Patient not currently intoxicated (alcohol or other drugs)
	- No history of complicated AWS (seizures, hallucinosis, DT)
	- No significant medical or psychiatric comorbidities
	- Patient ability to comply with outpatient visits and therapy
Inpatient detoxification or medical unit	- No underlying medical or surgical condition requiring ICU-level care
	- Normalization or near-normalization of vitals within ED
	- Clear sensorium
	- Responsive to 10–20 mg diazepam
	- Tolerates 2–4 h between benzodiazepine doses
	- Presence of medical or psychiatric condition requiring inpatient admission

**Alcohol Withdrawal Treatment**

Treating AW involves a thorough physical examination in all heavy drinkers who are considering abstinence. The physical exam should include a search for evidence of liver failure,



gastrointestinal bleeding, cardiac arrhythmias, infection, and glucose or electrolyte imbalances (Jameson et al., 2018). Management for any patient with suspected AW is initial resuscitation and rehydration. It is also important to provide adequate nutrition and oral multiple B vitamins, including 50–100 mg of oral thiamine daily for a week or more. Because most patients withdrawing from alcohol use disorders are either normally hydrated or mildly overhydrated, IV fluids should be avoided unless there is a relevant medical problem or significant recent bleeding, vomiting, or diarrhea (Grover & Ghosh, 2018; Jameson et al., 2018).

The treatment of AW focuses on addressing the underlying pathophysiology of withdrawal, which will both alleviate the patient's symptoms and prevent progression to DT. Because withdrawal symptoms reflect the rapid removal of a Central Nervous System (CNS) depressant, alcohol, the symptoms can be controlled by administering any depressant in doses that decrease symptoms (e.g., a rapid pulse and tremor) and then tapering the dose over 3–5 days (Grover & Ghosh, 2018). Although most depressants are effective, benzodiazepines are the preferred class of drugs due to having vast and significant research support and the highest margin of safety (Grover & Ghosh, 2018; Long, Long, & Koyfman, 2017). AW patients are in a state of CNS hyperstimulation due to loss of GABA inhibitory effect, and thus the primary treatment is providing GABA agonism. Benzodiazepines act as central GABA agonists, increasing the frequency of GABA-receptor channel opening. Benzodiazepines treat the psychomotor agitation experienced by withdrawing alcoholics in addition to preventing progression to more serious withdrawal symptoms (Jameson et al., 2018; Mainerova et al., 2015; Schmidt et al., 2016).

Most medical providers use drugs with longer half-lives (e.g., chlordiazepoxide), adjusting the dose if signs of withdrawal escalate, and withholding the drug if the patient is sleeping or has orthostatic hypotension. The average patient requires 25–50 mg of chlordiazepoxide or 10 mg of diazepam given as needed every 4–6 hours on the first day, with doses then decreased to zero over the next 5 days (Grover & Ghosh, 2018; Long, Long, & Koyfman, 2017).

### **Assessment of Alcohol Withdrawal**

Several scales are commonly and freely available for symptom assessment and withdrawal severity. One of the most commonly utilized systems is the Clinical Institute Withdrawal Assessment for Alcohol scale, revised (CIWA-Ar). Of note, AW is a clinical diagnosis, and this scale is used for assessing the severity of symptoms. Scoring is based on patient symptoms: nausea/vomiting, tremors, paroxysmal sweating, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache/head fullness, and orientation/clouding of sensorium. The maximum score of the CIWA-Ar scale is 67. Mild withdrawal is defined by a score of 15 or less, moderate is 16–20, and severe withdrawal is a score > 20. For CIWA-Ar monitoring, evaluations as frequent as every 10–15 min will be needed in initial stages of management. Once symptoms are under control, hourly reassessment with CIWA-Ar is effective (Saitz, 1994; Sullivan, Sykora, Schneiderman, Naranjo, & Sellers, 1989).

### Presentation of Symptomology.

Table 4 presents a general guideline for the progression of alcohol withdrawal symptoms. Minor symptoms are demonstrated within 6 to 12 hours after the last alcoholic beverage is consumed. Mr. Greene demonstrated tremors (1) as reported in the depositions jail personnel and nearby inmates. Stage II symptoms were also observed which include visual and audio dysperceptions (2) (later emerged as full hallucinations) (14, 15). Additionally the timing if the appearance these symptoms corresponds with what would be predicted in Table 5. While there was no indication of seizure; hallucinations (14, 15), delusions (2, 14, 15), hyperthermia (3) (e.g. sweating; removing clothing), and general psychosis emerged after 48 hours indicating the presence of delirium tremens (See Table 4 and Table 5).

**Table 4.**

Table Signs and symptoms of alcohol withdrawal syndrome, presented per stage

Stage	Time of onset after last drink (hr)	Signs and symptoms
I: minor withdrawal symptoms	6-12	Tremors, diaphoresis, nausea/vomiting, hypertension, tachycardia, hyperthermia, tachypnea
II: alcoholic hallucinosis	12-24	Dysperceptions: Visual (zooscopy), auditory (voices) and tactile (paresthesia)
III: alcohol withdrawal seizures	24-48	Generalized tonic-clonic seizures (with short or no postictal period)
IV: delirium tremens	48-72	Delirium, psychosis, hallucinations, hyperthermia, malignant hypertension, seizures and coma

**Table 5. Observational jail log for Mr. Greene**

12/4/17 @ 12:27 PBT test .194  
 12/4/17 @ 13:07 Greene back in court  
 12/4/17 @ 13:27 Retrieving Greene from court.  
 12/5/17 @ 22:44 Greene returns from shower  
 12/6/17 @ 13:40 Greene acting erratic, appears to be hallucinating, and detoxing  
 12/7/17 @ 06:20 Greene showing signs he is going through withdrawal  
     Tried to leave cell  
     Asked for a hammer and nails  
     Thought his mother was speaking to him  
     Periodically yells out and bangs on door, floor, or walls.  
     Does not comprehend he is in jail  
 12/7/17 @ 07:13 Christman tried to get him to lay down and sleep  
 12/7/17 @ 07:13 Greene hyper and agitated  
 12/7/17 @ 09:47 Green still has not slept, still agitated  
 12/7/17 @ 14:11 Nancy from CMH is speaking with Greene  
 12/8/17 @ 07:39 Co Avalos checks on Greene – Unresponsive

### Interventions in the case of Mr. Greene.

Mr. Greene entered a jail cell with a documented breath alcohol concentration (BrAC) of .194 at 1227 hours (4). A signed declaration from a witness (27) indicates that Mr. Greene's last ingestion of alcohol was approximately 0730 hours meaning that approximately 4 hours and 57 minutes had elapsed since the last known consumption. According to Dubowski (1985) Mr. Greene's peak BrAC occurred between 15 minutes and 4 hours 3 minutes meaning Mr. Greene was already declining in BrAC at the time the BrAC was measured. Therefore, Mr. Greene's BrAC was greater before he arrived at the jail. Furthermore, jail records indicate that Greene could not recall the last time he was sober (5). Greene's statements indicate he was a chronic alcohol user with a history of alcohol-related legal issues (5) therefore indicating an elevated risk for severe alcohol withdrawal syndrome. These facts alone would have elevated the observation of symptoms and referral to medical professionals as a high priority to avoid the development of delirium tremens and possible mortality. Neither occurred for Mr. Greene while he was incarcerated.

In fact, the treatment for Mr. Greene consisted of being housed in an observation cell (5) with provisions of food, water, and access to a shower (6). He was observed by non-medically trained jail personnel (8) and nearby inmates (9) for nearly four days (10). Multiple witnesses (11) indicate in testimony and logs that Greene was experiencing insomnia (12), visual (13) and auditory (14) hallucinations, and psychomotor agitation (15). Diagnosis of alcohol withdrawal syndrome was possible at this point as indicated by the *cessation of alcohol consumption* (incarcerated with a BrAC of .194; (4) and the presence of *any two of the aforementioned symptoms* (Table 1 (above)). Mr. Greene also demonstrated risk factors associated with delirium tremens including withdrawal longer than 2 days, gender of male, age over 30, and a long history of heavy alcohol consumption (Long, Long, & Koyfman, 2017). As such, Mr. Greene should have been considered a *high risk for delirium tremens and immediate medical attention sought* (Long et al., 2017) to administer the recommended course of medical treatment (typically a benzodiazepine taper; Foertsch et al., 2019; Long, Long, & Koyfman, 2017; Mayo-Smith, 2004) and medical monitoring (Foertsch et al., 2019; Long, Long, & Koyfman, 2017; Mayo-Smith, 2004).

Mr. Greene had only normal jail oversight while in incarceration. Deposition records attest to the fact the jail staff were trained on alcohol withdrawal, delirium tremens, and appropriate interventions (16). Documentation via jail logs and disclosures in depositions indicate that multiple corrections officers were involved in observing Mr. Greene's detoxification process. All jail personnel caring for Mr. Greene did not use that training and did not provide any intervention other than observation and basic necessities. Personnel monitored symptoms but did not raise the question of Mr. Greene needing medical intervention.

The only intervention in a proactive direction was the referral for an evaluation by a mental health professional (17). However, the referral was ordered to rule out other mental health issues (26), not the severity of alcohol withdrawal nor delirium tremens (18). Furthermore, the mental health professional involved in the evaluation was credentialed as a

*limited license professional counselor* (e.g. <2000 hours experience; under direct supervision of a fully licensed professional; Michigan Department of Licensing and Regulatory Affairs (LARA)) with no formal substance use training (18, 19). The supervisor, who was not on site, for this licensed professional was *certified* as an *Advanced* Addiction and Drug Counselor (20); however, she failed to provide adequate supervision over the case (as indicated in her own testimony (21); and did not advise on the evaluation of AW, let alone the development of DT (22). It is important to note that a mental health supervisor is required to oversee ALL cases for their supervisees to ensure ethical and effective treatment (LARA, Michigan Code of Ethics). Additionally, the CAADC of the supervisor requires training, experience, and evaluation of knowledge of substance use disorders (Michigan Certification Board for Addiction Professionals - Certified Advanced Alcohol and Drug Counselor, 2019), specifically in the area of alcohol and drug withdrawal (23); yet, according to the record, she has no recollection of such training (24) and failed to provide information to her supervisee. Furthermore, the court record provides the supervisor's admission that she received her alcohol and drug training at Western Michigan University. As Director of the Alcohol and Drug Program, one of the authors of this document can attest to two required graduate courses that explicitly cover and test for alcohol and drug withdrawal symptoms, diagnosis, and required medical interventions. As such, the mental health supervisor was educated and certified in alcohol withdrawal, but failed to impart that knowledge on her supervisee.

Regardless of personnel training, assessment of the necessity for medical intervention need not be from a mental health or medical professional given the plethora of screening instruments available. One possible instrument that could have been used by non-medical and/or mental health professionals is the CIWA-Ar. The CIWA-Ar is freely available and reproducible in the public domain (Carcaño-Calderón et al., 2015) and the 5-minute administration could have provided essential information for the treatment of Mr. Greene. Greene had an estimated score indicating a moderate, and possibly severe, level of alcohol withdrawal symptoms (See Table 5) which indicate immediate medical attention was warranted. The CIWA-Ar score would have been a decision point for personnel to engage in an immediate medical intervention, yet no medical intervention was called for during the period of incarceration lasting more than 4 days (25).

In summation, given Mr. Greene's symptoms and risk factors, and the recommended course of treatment, discerned the need for medication-assisted alcohol detoxification under medical supervision in a medical facility. The time the intervention should have occurred was at the point of displaying withdrawal symptoms, when hallucinations became apparent, or when the withdrawal symptoms reached the second day of duration. In fact, the presence of hallucinations alone, is the pathognomic indicator of the onset of delirium tremens and requires immediate medical attention (Grover & Ghosh, 2018; Long, Long, & Koyfman, 2017). However, Mr. Greene received no screening from basic alcohol withdrawal screening instruments, no professional assessment for AW nor DT, no diagnosis by a medical or mental health professional regarding alcohol withdrawal, and no medical intervention of any kind. As such, Mr. Greene did

meet the criteria for DT and the life threatening symptoms associated with it by staff who were trained to identify these symptoms (jail personnel) and mental health providers (CMH) who are professionally responsible to know these symptoms and to immediately refer for medical assistance to be provided to Mr. Greene.

### Depositions, Exhibits, and Logs.

1. [tremors]  
DepTrans Larry Foster pp. 51:16, 53:3-8  
Katie Tessner Exhibits pp. 62:20;  
DEPTRANS.ReneeChristman Exhibits pp. 50-51.
2. [dysperceptions]  
McCleeryTerry\_Full pp. 10:1-8  
00667619 (003) pp. 9, 15.
3. [hyperthermia]  
McCleeryTerry\_Full page 21:3-9;6  
00667619 (003) pp. 12, 14, 15
4. [BrAC]  
Crawford County Sheriff Office Daily Log  
Crawford County Medical Report page 1  
Jail Video Log page 1
5. [sober]  
Jail Crisis Screening Contact page 2
6. [observation cell]  
Crawford County Recs  
"Drunk tank" DepTrans William Denno pp. 34:21  
"observation area" DepTrans Renee Christman pp. 9:6
7. [shower]  
Jail Video Log page 14  
Daily Jail Log Report page 5
8. [personnel]  
Amy Johnson Exhibits pp. 13-35, 40, 48, 49, 55, 57-61  
Katie Tessner Exhibits pp. 16-27, 31-40, 46-48, 52-55, 62, 63  
Renee Christman Exhibits pp. 22,24,25-32, 42, 45, 48-52, 64, 67-74, 77-81, 83, 85-88,  
91, 93, 95, 121, 125, 133
9. [inmates]  
Dep Trans William Denno pp. 24-35  
Dep Trans Wade Schmidt pp. 8-17; 20-25
10. [4 days]  
Daily Jail Log Report (entire log)
11. [witnesses]  
Amy Johnson Exhibits pp. 13-35, 40, 48, 49, 55, 57-61  
Katie Tessner Exhibits pp. 16-27, 31-40, 46-48, 52-55, 62, 63  
Renee Christman Exhibits pp. 22,24,25-32, 42, 45, 48-52, 64, 67-74, 77-81, 83, 85-88,  
91, 93, 95, 121, 125, 133  
Dep Trans William Denno pp. 24-35  
Dep Trans Wade Schmidt pp. 8-17; 20-25
12. [insomnia]  
Daily Jail Log Report Page 11  
McCleeryTerryFull pp. 17:24-25 and 18:1.
13. [visual]  
Daily Jail Log Report Page 10  
DepTrans Kaminski 31:5
14. [auditory]  
Daily Jail Log Report Page 10  
DepTrans McCleary 9:23



15. [agitation]  
Daily Jail Log Report Page 11  
DepTrans Foster pp. 12:14, 62:21  
MccleeryTerryFull 9:15-24; 15:9-23  
DepTrans Kaminski 31:4
16. [interventions]  
DepTrans Joannie E. Blamer pp. 21, 23-27, 30, 33, 39, 42, 48, 50, 52
17. [professional]  
RECORDS Jail Crisis Screening pp.1
18. [tremens]  
RECORDS Jail Crisis Screening pp.3
19. [training]  
DepTrans Nanci Karczewski pp. 8, 9
20. [counselor]  
DepTrans Staci Kaminski 12:15
21. [testimony]  
Staci Kaminski pp. 19,21,26,27,42,45
22. [DT]  
Dep Trans Staci Kaminski page 31
23. [withdrawal]  
Domains2017 pp. 2
24. [training]  
Dep Trans Staci Kaminski pp. 19,21,26,27,42,45
25. [4 days]  
Daily Jail Log Report (entire log)
26. [rule out other mental health]  
Suiter Dale Cond N Page 13:15-21  
Avalos Joe Cond N Page 60:1-3
27. [signed declaration of]  
Declarationofjessicamunger Page 2

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